STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

California State Athletic Commission
1424 Howe Ave. Ste. #33
Sacramento, CA 95825
www.dca.ca.gov/csac/
(916) 263-2195 FAX (916) 263-2197

PROFESSIONAL ATHLETE OPHTHALMOLOGIC EXAMINATION

***Only** a licensed Physician who specializes in Ophthalmology may conduct this examination and complete this form. Please complete this form in its entirety.*

BOXING **MIXED MARTIAL ARTS** **KICKBOXING**

Office Use
Approved by: _____
Date: _____

First **Middle** **Last** **Telephone** **Date of Birth**

Address **City** **State** **Zip Code** **Country**

HISTORY – Please provide the following information:
Has applicant ever had any of the following conditions:
1. Blurred vision? **Yes** **No**
2. Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye? **Yes** **No**
3. Has applicant had or been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens, or cataract?
Yes **No** If yes, please explain:_____
4. Eye Disease? **Yes** **No** List nature of diseases or injuries:_____
5. Eye Injury? **Yes** **No** List nature of diseases or injuries:_____
6. Retinal re-attachment? **Yes** **No** If yes, please explain: _____
7. Does the applicant have any other visual condition that would prevent him/her from safely engaging in boxing or martial arts activities? **Yes** **No** If yes, please explain: _____

EXAMINATION

VISION: Without / With Glasses
Right _____/_____
Left _____/_____
Remarks: _____
_____
_____
_____

REFRACTION: If either eye is 20/60 or worse:
Right _____ Sph_____ Cyl x_____ Acuity_____
Left _____ Sph_____ Cyl x_____ Acuity_____
Intraoccular Right_____mmHg
Tension Left _____mmHg
Motility Normal _____ Abnormal _____
Binocular Vision Normal _____ Abnormal _____

SLIT LAMP EXAM	**NORMAL** Right/Left	**ABNORMAL** Right/Left	**SPECIFY ABNORMALITIES**
Conjunctiva			
Cornea_____	_____/_____	_____/_____	_____
Iris/Pupil_____	_____/_____	_____/_____	_____
Lens_____	_____/_____	_____/_____	_____
Eyelids_____	_____/_____	_____/_____	_____

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ATHLETE OPHTHALMOLOGIC EXAMINATION

APPLICANT NAME: _____

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)	**NORMAL** Right/Left	**ABNORMAL** Right/Left	**SPECIFY ABNORMALITIES**
Disc _____	_____/_____	_____/_____	_____
Macula _____	_____/_____	_____/_____	_____
Lens_____	_____/_____	_____/_____	_____
Peripheral Retina _____	_____/_____	_____/_____	_____

Title 4, Rules and Regulations, §282 states: The commission **shall** deny, suspend, revoke, or place restrictions on the license of a professional or amateur boxer or martial arts fighter because of a medical or visual condition, including but not limited to one of the following:

1) Uncorrected visual acuity of less than 20/200 in either eye or 20/60 with both eyes;
2) Corrected visual acuity of less than 20/60 in either eye, regardless of its cause;
3) A visual field of 60 degrees or less extending over one or more quadrants of the visual field;
4) Presence or history of retinal detachment or retinal tear unless treated by an ophthalmologist and then approved by an ophthalmologist specified by the commission who then assesses that the boxer is at no significant risk of further injury to the retina if boxing is resumed. Such assessment shall occur both within five days before and five days after the contest;
5) Presence of primary or secondary glaucoma, whether or not such condition has been treated;
6) Presence of aphakia, pseudophakia, dislocated lens or cataract in either eye;
7) Any other visual condition which the commission determines would prevent the applicant or licensee from safely engaging in boxing activities.

Examining physician: Any of the above conditions **MUST** be reported immediately to the Commission. **DO NOT** clear the applicant to compete if the applicant has one or more of the above symptoms. Please immediately forward a copy of any report, directly to the commission, for any applicant who has a condition that may preclude him/her from being licensed.

PHYSICIAN STATEMENT: I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on the other side of this form.

PHYSICIAN'S REMARKS: _____

_____

Based on your personal observation and review of the test results and considering Commission Rule 282 above, is it your medical opinion that this applicant is physically fit to be licensed and compete in combative sports? **Yes** **No**
If no, please explain: _____

_____

_____

LICENSED PHYSICIAN'S NAME (print) **MEDICAL LICENSE NUMBER**

ADDRESS **CITY** **STATE** **ZIP CODE**

TELEPHONE NUMBER **DATE/TIME**

PHYSICIAN'S SIGNATURE

Revised December 2007